

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/23/2009
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An unannounced initial Medicare/Medicaid certification survey was conducted at this facility from November 20, 2009 through November 23, 2009. The facility census on the entrance day of the survey was 3 residents. The survey sample was composed of 3 residents. The survey process included observations, staff and resident interviews and review of resident charts and facility policies and procedures. No deficiencies were observed during this survey.</p> <p>This facility was found to be in substantial compliance with 42 CFR Part 483, Requirements for Long Term Care.</p>	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLICRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

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NAME OF FACILITY: CADIA REHABILITATION PIKE CREEK

DATE SURVEY COMPLETED: November 10, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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An initial State licensure survey was conducted at the facility on November 10, 2009.

No state deficiencies were noted at the time of the survey.

Provider's Signature _____

Title _____

Date _____